Teaching Doctors How to Improve Care and Lower Costs…at the Same Time

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—By Eve Glicksman

Medical overspending is one of the major contributors to rising health care costs in the United States. A 2012 Institute of Medicine (IOM) report documented that the United States spends $750 billion annually on unnecessary tests and procedures as well as avoidable hospitalizations, emergency room visits, and medications. As other studies corroborate these findings, there is growing consensus that physicians on the front lines must help to identify and eliminate wasteful spending.

Instilling cost awareness in physicians and asking them to consider costs in their diagnostic and treatment recommendations, however, is a challenge requiring a cultural shift from deeply entrenched values and practices in medicine. The traditional medical training model purposefully insulated physicians from patients' medical bills and hospital fees. The long-held thinking has been that medical decisions should be based on clinical knowledge; anything less could compromise care.

"We thought we were doing the right thing to be cost-blind, but we're now catching up," said James Salwitz, MD, president of the staff at Robert Wood Johnson University Hospital and clinical professor at Rutgers Medical School.

Today, doing what's best for the patient includes balancing the costs of diagnosis and treatment choices with their medical value and risk. Many physicians learn the lessons of value-based care through experience. In fact, a study published in the November 2012 *Health Affairs* found that a doctor's costs decreased each decade he or she practiced. But why not cultivate smarter spending habits in medical students and residents at the start to take the strain off a beleaguered health care system?

In 2011, the American College of Physicians called for high-value, cost-conscious care to become a critical competency for physicians. But change has been slow, and most students and residents have limited opportunities during training to devise cost-effective diagnostic

strategies. Medical training, lectures, and rounds typically are short on instruction about resource stewardship, cost-effective choices, or how insurance works.

Medical faculty should take a greater leadership role in exposing students and residents to “the reality of costs” during training, said Salwitz. “We have to explain early on why this is a core skill—not just an extra burden.”

Christopher Moriates, MD, co-author of “First, Do No (Financial) Harm,” in the *Journal of the American Medical Association* (JAMA), August 2013, maintains that physicians must consider the financial impact on patients and society before making clinical decisions. With more Americans enrolled in high-deductible insurance plans, ordering more tests than necessary can lead to steep out-of-pocket costs. These expenses can cause patients to postpone or forgo needed care. Financial stress can adversely affect health, too.

“There are many drivers in this [overspending and over-testing] problem, but a big piece is in our control,” said Moriates, co-author of *Understanding Value-Based Healthcare*, a 2015 textbook for medical educators and clinicians. Moriates is a leader in advocating for curriculum changes that teach residents the fundamentals of balancing cost and high-quality care. At the University of California, San Francisco (UCSF), where he serves on the faculty, he established a resident-designed, resident-led, cost-awareness curriculum for internal medicine trainees. It is one of several model programs that are trying to address this critical gap in medical education.

Bringing value into the equation

The High Value Care Curriculum (HVC), created by the American College of Physicians (ACP) and the Alliance for Academic Internal Medicine in 2012, is the largest effort of its kind to merge lessons about cost awareness and quality care. Cynthia Smith, MD, director of clinical program development at ACP, led the effort to develop the curriculum, which uses a stepwise framework for value-based decision making.

The HVC consists of six one-hour interactive modules in which residents and faculty discuss benefits and costs of different treatment options in the context of real patient cases. The training introduces simple interventions to reduce or eliminate unnecessary tests, medications, and procedures while improving outcomes. Residents learn how to make more judicious decisions about when to use the ER or when a patient would benefit from inpatient

care. In addition, residents are encouraged to provide high-value preventive care such as vaccinations, colon cancer screening, and smoking cessation counseling.

The curriculum, available online for any institution at no cost, includes a facilitator guide for each session. ACP also created a webinar and workshop to help faculty teach the curriculum. The approach was designed for residents because they were identified as “potential change agents,” Smith said. More than half of internal medicine residency programs are using some component of the HVC curriculum, she added. Currently, ACP is working with surgeons, pediatricians, and other specialists to modify the modules for their residents. In addition, ACP is collaborating with MedU to adapt the same learning framework and curricular materials for medical students.

Many faculty physicians admit they do not feel qualified or comfortable teaching value-based care, however, because they were not trained that way themselves. In response, the American Board of Internal Medicine Foundation (ABIMF) teamed up with another organization, Costs of Care, to create the ABIMF Costs of Care Teaching Value Project. This initiative piggybacks on the ABIMF Choosing Wisely campaign for practicing physicians, launched in 2012, which introduced best practice recommendations on common tests and procedures drawn from evidence-based studies. The newer program focuses on training physicians to teach the lessons of Choosing Wisely to medical students and residents.

“If we want to teach the next generation [about value-based care], we need faculty development in those competencies,” said Janine Shapiro, MD, medical director for continuing medical education and associate dean for faculty development at the University of Rochester School of Medicine and Dentistry. She calls it the “reverse continuum”—teaching faculty those skills so they can train residents and students.

The school has been participating in the AAMC’s Teaching for Quality (Te4Q) program, which helps clinical faculty to improve their teaching and assessment strategies on quality improvement and patient safety. “Te4Q is providing high-quality care at lower cost. We know poor quality drives cost up. If we improve quality (less morbidity and mortality, fewer errors), we lower costs automatically,” said Shapiro, who also is a professor of anesthesiology.

“Evidence-based medicine is the hook,” said Moriates about the resident training he implemented at UCSF. The training teaches residents how to determine which tests add

value to patient care and which do not when they are performing workups. For example, Moriates asked, “When is an MRI worth twice as much as a CT?” The case-based approach at UCSF discourages residents from ordering costly tests to anyone who fell or has a headache, for example, unless there is an evidence-based reason. As a result of this approach, Moriates said nebulizer use plummeted and fewer transfusions were performed at the university’s hospital. Patient outcomes also improved, he said.

UCSF residents are asked to use bills, price lists, and clinical data to identify areas of duplicate testing or other wasteful spending. “It’s eye-opening for [residents] to look at patient bills and charges and to see the dollars associated with these tests. They learn to critically examine the price of what they do during training,” said Moriates.

“’Choosing Wisely’ is not about saying no,” stressed John Prescott, MD, chief academic officer at the AAMC. “It is about giving thought to the decision.”

Beyond the curriculum

Curriculum content that raises cost awareness is only one strategy to curtail medical overspending. At the nation’s Veterans Affairs hospitals, for example, a failure to seek competitive bidding on medical products and supplies led to reports of overspending. Some advocates for lowering costs recommend a reward system that values cost-effective care and discourages extensive differential diagnoses testing.

Large-scale cultural change can’t happen in a silo, said Dave Davis, MD, AAMC senior director of continuing education and performance improvement, who oversees the Te4Q program. “[Value-based care] efforts are much more effective when collaborating with a team. The principles must be shared by supervisors, clerks, and faculty. They all should be using the same language.”

As a first step, Moriates recommended that institutions “find a champion to drive the culture change.” The UCSF Center for Healthcare Value has undertaken a comprehensive initiative to define competencies for cost awareness at all levels of training and across disciplines.

Once everyone is on board, clinical faculty have to start asking questions during rounds about why a particular test was ordered and whether it will change the diagnosis or how care is managed. Executives and administrators may need to be involved to make system

oversight changes that ensure unnecessary tests are not approved or to enforce adherence to competitive bidding policies.

At the same time, physicians and residents must have greater access to cost information about tests and procedures. At the end of 2010, as the HVC project was getting off the ground, only 20 percent of internal medicine faculty and residents knew where to find the estimated costs and charge data of common tests and treatments, Smith noted.

Revising the curriculum to cover value-based care is only the conversation starter, she added. “The challenge is to take these discussions from conference room to bedside.”